1. PERSONAL INFORMATION

MAIL ORDER REGISTRATION

Beneficiary

SPONSOR IDENTIFICATION NUMBER

NOTE: ID Number may not fill all boxes.

Beneficiary First Name **M.I.** **Last Name**

Birth Date M M - D D - Y Y Y Y **Gender**

Physician Last Name (If Known) **Physician Phone # (If Known)**

- -

Family Member 1

FAMILY MEMBER 1 IDENTIFICATION NUMBER

NOTE: ID Number may not fill all boxes.

Family Member 1 First Name **M.I.** **Last Name**

Birth Date M M - D D - Y Y Y Y **Gender**

Physician Last Name (If Known) **Physician Phone # (If Known)**

- -

Family Member 2

FAMILY MEMBER 2 IDENTIFICATION NUMBER

NOTE: ID Number may not fill all boxes.

Family Member 2 First Name **M.I.** **Last Name**

Birth Date M M - D D - Y Y Y Y **Gender**

Physician Last Name (If Known) **Physician Phone # (If Known)**

- -

Family Member 3

FAMILY MEMBER 3 IDENTIFICATION NUMBER

NOTE: ID Number may not fill all boxes.

Family Member 3 First Name **M.I.** **Last Name**

Birth Date M M - D D - Y Y Y Y **Gender**

Physician Last Name (If Known) **Physician Phone # (If Known)**

- -

Drug Allergy Conditions

INSTRUCTIONS FOR COMPLETING THE DRUG ALLERGY CONDITIONS: For each beneficiary, mark an "X" in the appropriate box. If an allergy has occurred with a medication not listed below, please list it in the space provided at the bottom of this chart.

	Beneficiary	Family Member 1	Family Member 2	Family Member 3
(00) No known allergies				
(01) Penicillins (Ampicillin, Amoxicillin, Others) and Cephalosporins (Keflex, Velosef, Suprax, Cefzil, Others)				
(03) Aspirin and non-steroidal pain relievers (Vioxx, Ibuprofen, Naproxen, Celebrex®, Others)				
(04) Codeine				
(15) Sulfa Type Drugs (Celebrex®, Glyburide®, Glucotrol®, Micronase®, Others)				

Please list other health conditions, medications, and drug allergies

2. SHIPPING INFORMATION

NOTE: You must provide a U.S. postal address. Prescriptions cannot be mailed to private foreign addresses.

First Name **Middle Initial**

Last Name

(U.S. Postal Address, including APO/FPO)

City

State **ZIP or Postal Code** -

Phone # - -

3. PAYMENT INFORMATION

Standard delivery of your order is **FREE**. Your order will arrive within 14 days from the date we receive your order.

To expedite shipping, you may choose to have your order sent by next-day delivery, after it is processed, for an additional charge. (NOTE: This will only affect shipping time, not the processing of your order.)

Please include payment with your order. **DO NOT SEND CASH**. To calculate your payment, please refer to your *Beneficiary Guide* for your copayment. Add $18 if you want next-day delivery.

Check/Money Order **Amount Enclosed** $.

Credit Card # **Expiration Date** M M - Y Y

Credit Card # **Expiration Date** M M - Y Y

NOTE: All future orders will be charged to this credit card, unless payment (check) accompanies the order.

Cardholder Name _____

Please print name as it appears on credit card

x AUTHORIZED SIGNATURE

As required by the U.S. Department of Defense, we will dispense FDA-approved generic medications unless your physician establishes that the brand-name medication is medically necessary.

4. SIGNATURE INFORMATION

IF APPLICABLE, PLEASE SIGN THE FOLLOWING STATEMENTS:

I request that this and future orders be shipped "Signature Required". I understand there will be an additional charge for this service.

x AUTHORIZED SIGNATURE

I would like my prescriptions dispensed with **NON-CHILD** resistant caps.

x AUTHORIZED SIGNATURE

REVIEW YOUR PRESCRIPTION

- **Check to see if the patient name is clearly written on the prescription.** If not, print the patient's full name, address and phone number on the back of the prescription.
- **Check to see if the physician's signature is legible.** If not, please circle the physician's preprinted name on the prescription, or print the name of the physician on the back of the prescription.
- **Check to see if the physician's phone number is printed on the prescription.** If not, print the physician's phone number, including area code, on the back of the prescription.
- **If there are more than 3 Family Members, write the information on a separate piece of paper.**

INSTRUCTIONS FOR COMPLETING THIS FORM

- Complete all portions of this form by printing in **ALL CAPITAL LETTERS** using **BLACK INK**.
- Make sure you have **completed** the Drug Allergy Conditions section. This enables our pharmacists to review your patient record prior to filling prescriptions.
- Fold the completed form and place it along with your prescriptions in an envelope addressed to: **Express Scripts PO BOX 52150 PHOENIX, AZ 85072-9954**.
- Include your check or money order (if not paying with a credit card).

HEARING IMPAIRED: 877.540.6261
FOR REFILLS: www.express-scripts.com
Toll-Free: 866.DOD.TMOP (866.363.8667)